Benefits Summary
Permian Basin Employer Health Plan
Business Cooperative
Plan A - High (2000)

COVERED SERVICES	MEMBER RESPONSIBILITY
Aggregate Lifetime Maximum Benefit	**$1,000,000**
Calendar Year Deductible	**$2,000 per Member**
Out-of-Pocket Maximum	**$10,000 per Member**
Outpatient Services	
Physician office visits including laboratory, radiology, medication, supplies and materials administered in the Physician's office. Additional Copayments apply for surgical procedures. ◆ Primary Care Physician	$25 per visit to the PCP*
◆ Specialist	$55 per visit to the Specialist*
Laboratory Services	Less than $1,000 - No Copay* - Greater than $1,000 - 20% of the Allowable Amount*
Diagnostic Radiology Services (except for the following): ◆ MRI, CT, Ultrasound, Sonogram, Nuclear Medicine, PET	No Copay* $125 per procedure
Surgical Procedures performed in the Physician's office	$75 per procedure
Pre and Post-Natal Obstetrical Care	No Copay*
Rehabilitation, Speech, Occupational and Physical Therapy	$25 per visit
Outpatient Surgery	$300 per admission
Physician Home Visits	$50 per visit
Allergy Services ◆ Office Visits including Testing ◆ Serum ◆ Injection Administration	 $25 per visit to the PCP*; $55 per visit to the Specialist* 50% of the Allowable Amount 50% of the Allowable Amount per visit
Short-term Mental Health Services Limited to 20 visits per Calendar Year	$55 per visit
Serious Mental Illness Health Services Limited to 60 visits per Calendar Year	$55 per visit
Chemical Dependency Services Limited to 3 series of treatments per lifetime	$55 per visit
Preventive Health Care Services	
Routine Physical Exams	$25 per visit to the PCP*
Well-Baby and Well-Child Care	$25 per visit to the PCP*
Routine Immunizations	No Copay*
Well-Women Examinations	$25 per visit*
Screening Mammograms	No Copay*
Bone Mass Measurement	No Copay*
Examinations for Detection of Prostate Cancer	Included in the office visit Copay*
Routine Sight, Speech and Hearing Screenings for Children	No additional Copay required when performed during an office visit*
Screening for the Detection of Colorectal Cancer	No Copay*
Family Planning and Infertility Services	
Family Planning Counseling	25 per visit to the PCP*; $55 per visit to the Specialist*

* No Deductible

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Family Planning and Infertility Services (contiuned)	
Contraceptive Devices and Implants ◆ Diaphragm ◆ IUD ◆ Subdermal Contraceptive Implants & Removal	20% of the Allowable Amount for all charges Applies to materials, procedures and services
Sterilization Performed at an Outpatient Surgical Facility	$300 per admission
Sterilization Performed in the Physician's office	$50 per procedure
Infertility Services	Not Covered
Inpatient Services	
Inpatient Admissions including: ◆ Chemical Dependency Treatment Center ◆ Psychiatric Hospital ◆ Rehabilitation Facility ◆ Skilled Nursing Facility	*Chemical Dependency: Limited to 3 series of treatments per lifetime* *Short-Term Mental Illness: Limited to 15 Inpatient days per Calendar Year* *Serious Mental Illness: Limited to 45 Inpatient days per Calendar Year* *Skilled Nursing Facility: Limited to 100 days per Calendar Year*
Tier 1 Hospital - Contracted Hospitals within the Service Area Tier 2 Hospital - Contracted Hospitals outside the Service Area	Tier 1 - $200 per day per admission, Max per admission $1,000 Tier 2 - 30% of the Allowable Amount After Deductible
Observation Unit Admissions	$200 per admission
Other Health Care Services	
Home Health Services (except for Speech, OT & PT services)	$60 per visit
Non-Emergent Ambulance Services	$150 per trip
Prosthetics/Orthotics/Heart Implants (Pacemakers, Stents)	20% of the Allowable Amount per device
Durable Medical Equipment (DME) and Medical Supplies	30% of the Allowable Amount per piece of equipment or supply. DME is limited to $4,000 per Calendar Year. DME used in the treatment of diabetes, oxygen and monitoring devices are not included in the $4,000 maximum.
Insulin and Diabetic Medications (up to a 30-day supply) ◆ 1st Tier - Generic Drugs ◆ 2nd Tier - Selected List of Brand Name Drugs ◆ 3rd Tier - Other Brand Name Drugs not on 2nd Tier Mail Order (up to a 90-day supply) ◆ 1st Tier - Generic Drugs ◆ 2nd Tier - Selected List of Brand Name Drugs ◆ 3rd Tier - Other Brand Name Drugs not on 2nd Tier	 $15 per prescription* $35 per prescription* $65 per prescription* $45 per prescription* $105 per prescription* $195 per prescription*
Diabetic Supplies	30% of the Allowable Amount per item*
Diabetic Self-Management Education	$25 per visit to the PCP*; $55 per visit to the Specialist*
Hearing Aids	Coverage is limited to a maximum of $500 per ear once every 36 months
Dialysis Services	30% of the Allowable Amount
Organ Transplant Services	30% of the Allowable Amount
Immunosuppressive Medications, Injectable Drugs, Medically Infused Medications and Supplies, High Technology Drugs, Radiation Therapy, Chemotherapy and Associated Agents	**Lifetime Maximum Benefit- $250,000++** This does NOT increase the Aggregate Lifetime Maximum Benefit ◆ When cost is $500 or less: No copayment - Included in the office visit, outpatient surgery or inpatient hospital Copay. ◆ When cost is more than $500 - 30% of the Allowable Amount ++ This Lifetime Maximum Benefit does not apply to the treatment of cancer if after the initial diagnosis the member receives all cancer treatment in the Covenant Health System. If a member receives any cancer related service outside the Covenant Health System, the $250,000 Lifetime Maximum Benefit applies.
Hospice Services	No Copay
Pain Management Services	30% of the Allowable Amount
Emergency Services	
Emergency Room	$125 per visit
Minor Emergency or Urgent Care Center	$50 per visit
Ground Ambulance & Air Ambulance	$150 per ambulance trip after Deductible $1,000 Transfer to Tier 1 hospital, 30% of the Allowable Amount to Tier 2 hospital after Deductible

* No Deductible